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HOPP # 58

Policy Name:	*Member Complaint and Appeal Policy*

Policy Information:

Policy #	C.A. 001	**Originating Department**	Complaints, Grievances and Appeals
Revision	15.0		
Category		**Business Owner(s)**	Shannon Thomas
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Revision History:

Date	Revision	Reason
February 5, 2004	1.0	Replacement
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November 1, 2005	3.0	Revision
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January 24, 2012	10.0	Revision
January 29, 2013	11.0	Revision
March 4, 2014	12.0	Revision
June 2, 2015	13.0	Revision
July 26, 2016	14.0	Revision
October 9, 2018	15.0	Revision

Type	☐ New	☒ Revision	☐ Clarification	☐ Replacement

Applies To:

Medical Products	HMO based Medical Products	Medicare Advantage Products	Traditional Medical Products	Dental Products	Pharmacy Products	Group Insurance Products	Systems	Other
☒All ☐None ☐Medical Products	☒All ☐None ☐HMO ☐Open Access HMO ☐ USAccess ☐QPOS ☐Choice POS ☐Health	☐All ☒None ☐ Medicare ☐Medicare Prescription Drug (Part D)	☒All ☐None ☐Traditional Choice ☐Open Choice ☐Aetna HealthFund Open Choice ☐Managed Choice ☐Open	☒All ☐None ☐DHMO ☐ Indemnity ☐PPO	☒All ☐None	☐All ☒None ☐Traditional Short Term Disability ☐Traditional Long Term Disability ☐Managed Disability ☐ADS ☐Coordinated	☐All ☐None ☒HMO ☒ACAS ☐ Aecclaims ☐MCS ☒CAS ☒CATS ☒Target ☒MSW	☒ All ☐ None ☐ Discount Plans

	Network Option (HNO) ☐ Innovation Health ☐ Coventry Health Care Inc.		Access Managed Choice ☐Aetna HealthFund Open Access Managed Choice ☐Elect Choice ☐Open Access Elect Choice ☐Aetna HealthFund Open Access Elect Choice ☐Choice II ☐Flexible Spending Account ☐ Affordable Health Choices (Aetna Voluntary Plan (AVP), formerly SRC) ☐ Blanket Health (Aetna Student Health) ☐Aexcel ☐Innovation Health ☐Coventry Health Care Inc.			Disability ☐Group Long Term Care ☐Basic and Supplemental Group Life ☐Portable Supplemental Term Life ☐Group Universal Life	☒Data Migrator ☒ATV ☒ Aetna Strategic Desktop (ASD) ☒ Navigator ☒IDX ☒ Salesforce ☒HRP ☒ ActiveHealth ☒ ECHS	

Funding Arrangement	Group Arrangement:
Fully Insured (includes split funding arrangements) • Aetna Fiduciary **ASC (Self Insured)** • Aetna Fiduciary - Complaints and Appeals • Plan Sponsor Fiduciary – Complaints (Note: Policy is not applicable when appeals are handled by the Plan Sponsor)	☒ All ☐Employer Group ☐Blanket Health ☐Individual Conversion ☐Exchanges

Section I – General Standards

Purpose

The purpose of this policy is to establish standards across all affected functional areas for the evaluation, monitoring and resolution of verbal and written complaints and appeals submitted by Aetna members and/or their authorized representative.

Policy Statement

All member complaint and appeal investigation and resolution activities must be conducted in accordance with the standards outlined within this policy and as required by any related policies

and/or procedures. For purposes of these policies and the supporting procedures, Aetna means Aetna and any of its affiliates or acquisitions (e.g., Coventry, Innovation Health, etc.)

Responsibility
The Complaints, Grievances & Appeals Team is responsible for developing member complaint and appeal policies and procedures. The Resolution Teams are responsible for processing cases in accordance with these policies and procedures and any applicable state or federal law. The Resolution Teams will consult with Business Unit Subject Matter Experts (SME) as appropriate.

Confidentiality
All complaint and appeal resolution team members are expected to follow the confidentiality guidelines in the Aetna Code of Conduct and the Privacy and Information Security Policies. In addition, all complaint and appeal resolution team members are required to take updated training versions of these programs in accordance with company directives.

Record Retention
All documentation related to and created in response to complaints and appeals will be retained for a minimum of 10 years or longer as required by state or federal law or regulation, or current company policy.

Quality Review
All complaints and appeals are subject to the Quality Audit Program. A sample of closed files is reviewed each month to ensure the case was processed in accordance with this Policy and related procedures.

Application of State or Federal Laws and Regulations
To the extent that this policy, plan documents and/or plan sponsor performance guarantees vary from the applicable state or federal laws and/or regulations, the requirements of the law or regulation are adopted and supersede Aetna's written policy for those cases affected by the law. Aetna's law department makes the final determination when there is any question as to the applicability of a law.

Application of Plan Documents
To the extent that this policy varies from the Certificate of Coverage (COC), Summary Plan Description (SPD), or the Summary of Coverage (SOC) of an individual, the requirements of the COC, SPD or SOC supersede Aetna's written policy for those affected. However, if a regulatory requirement is more stringent than the COC, SPD or SOC, the regulatory requirement will be followed.

Application to Plan Sponsor Performance Guarantees
To the extent that this process varies from any Plan Sponsor performance guarantees, the performance guarantee will be followed. However, if an applicable regulatory requirement is more stringent than the performance guarantee, the regulatory requirement will be followed. Performance guarantees are managed through the Standards Management Unit.

Counsel Fees
Aetna has no responsibility to pay counsel fees or any other fees or costs incurred by a member pursuing a complaint or appeal.

Continuation of Coverage
Post-Service Appeals, where the service has been rendered and the claim was processed by the previous carrier, will be handled by the previous carrier.

If a pre-service denial was issued by a previous carrier and the service has not been rendered prior to the Aetna effective date, a new pre-certification request should be submitted to Aetna for consideration.

Roles
For complete summary, refer to the Roles and Responsibilities Summary and Resolution Team Routing Guide located on the CG&A website.

Section II – Definitions[1]

Adverse Benefit Determination	A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. This also includes rescissions of coverage for all types of plans and declination of coverage for individual plans only.
Appeal	A verbal or written request by a member or a member's authorized representative, requesting a change in the Initial Determination decision. This includes but is not limited to requests related to the following: (1) Certification of health care services; (e.g., pre-certification, concurrent review, retrospective services) (2) Claim payment (3) Plan interpretation (4) Benefit determinations (5) Eligibility (including issues where termination of coverage precludes the member from having services) Disputes regarding the member liability related to discount programs are not eligible for appeal. Aetna has three categories of appeals, each defined herein, that are addressed by the Member Complaint and Appeal Policy as follows: (1) Expedited; (2) Pre-Service; and (3) Post-Service
Appeal - Level One	An oral or written request by a member or a member's authorized representative requesting a change in the initial determination decision.
Appeal - Level Two	An oral or written request by a member or a member's authorized representative requesting a change in the Level I appeal decision.
Claim for Benefits	A benefit request which includes: • Bills submitted for services rendered, • Requests for pre-certification of services where the plan requires such pre-certification. An inquiry regarding eligibility of a member or whether a particular service is covered under the plan of benefits is not a claim for benefits unless

[1] Patient Management related definitions are summaries of the definition from the PM policy

	• the service to be rendered requires approval of the benefit in advance of obtaining medical care (pre-certification) and • the inquiry names the specific claimant, specific medical condition or treatment, and the service or product for which a precertification is requested.
Complaint	Any oral or written expression of dissatisfaction/concern, other than an appeal, by a member or a member's authorized representative regarding services provided by Aetna, a health care professional or a vendor, including but not limited to: • Potential quality of care by a participating health care professional • Quality of administrative service provided by a participating health care professional • Quality of administrative service provided by Aetna • Use of his/her protected health information • A plan benefit, billing, eligibility or contract provision that does not involve a request to review a denied claim • Issues regarding premiums excluding eligibility related issues.
Concurrent Care	An ongoing course of treatment to be provided over a period of time or number of treatments. Concurrent care includes services provided both inpatient and outpatient.
Concurrent Review	Concurrent review encompasses those aspects of Patient Management that take place during the provision of services at an inpatient level of care or during an ongoing outpatient course of treatment. • Provider requests for extension of coverage[2] for a course of clinically urgent inpatient or outpatient treatment received prior to the expiration of the current certified number of days/visits/treatments are handled expeditiously as an urgent concurrent review request. • Provider requests for routine extension of an ongoing outpatient course of treatment are handled as a new precertification request. **Note**: Aetna is required to continue **previously approved** concurrent services during the course of an appeal review until the determination is made. If this isan extension of services not previously approved, we are not required to continue services
Executive Appeal	An appeal sent to Aetna's President, CEO or Chairman, one of their direct reports, to a Board of Director member, to a Segment Head or to the Head of Service Operations, to a Legislative Representative or the Better Business Bureau.
Executive Complaint	A complaint sent to Aetna's President, CEO or Chairman, one of their direct reports, to a Board of Director member, to a Segment Head or to the Head of Service Operations, to a Legislative Representative or the Better Business Bureau.
Expedited Appeal	An oral or written appeal of a decision involving urgent care. Post service issues are not eligible for an expedited process.
Expedited Complaint	Any oral or written expression of dissatisfaction/concern by a member or a member's authorized representative, regarding an urgent matter, (i.e. member complains about inability to get a timely appointment when they feel their health could be jeopardized).
External Review	Independent, third party external review of coverage denials based upon Aetna's determination that the proposed or rendered service or supply is

[2] For these purposes, "coverage" means either the determination of (i) whether or not the particular service or treatment is a covered benefit pursuant to the terms of the particular member's benefit plan, or (ii) where a provider is required to comply with Aetna's Patient Management programs, whether or not the particular service or treatment is payable under the terms of the provider agreement.

	not medically necessary or is experimental/investigational in nature. **Note**: Under current Federal Regulation in effect until notification of change, denials based on medical judgment are included in this definition.
Health Care Professional	A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state or federal law. Examples include physicians, dentists, podiatrists, independent nurse practitioners, and institutional providers and suppliers of healthcare services including behavioral health care organizations.
Initial Determination	The first decision made for prospective or post-service care or services.
Medical Judgment	Issues related to medical necessity, experimental and investigational, cosmetic and level of care. It can also include the type of clinical review that helps determine if something is subject to a contractual denial (e.g., speech therapy).
Member's Authorized Representative	An individual representing the member in the appeal or complaint process. For appeals an individual must satisfy at least one of the following requirements. For complaints, an individual must satisfy requirement (a) or (b) (a) The member has given express written or verbal consent for the individual to represent the member's interests. . (b) The individual is authorized by law to provide substituted consent for a member (e.g., parent of a minor, legal guardian, foster parent, someone holding a power of attorney). (c) For pre-service, urgent care or concurrent care claims only, the individual is an immediate family member of the plan member (e.g., spouse, parent, child, sibling). (d) For pre-service, urgent care or concurrent care claims only, the individual is a primary caregiver of the member. (e) For pre-service, urgent care or urgent concurrent care claims only, the individual is a health care professional with knowledge of the member's medical condition (e.g., the treating physician). Exceptions to this process require approval of Regional Counsel.
One Step Resolution	When a Complaint or Appeal is entered into Complaint and Appeal Tracking System (CATS) and all information needed to handle and close the case is available, the case can be completed using the One Step Resolution process.
Overturn	A reversal of the initial determination or subsequent appeal determination. This may or may not result in the release of additional benefits.
Partial Overturn – aka Partial Uphold	A reversal of a portion of the initial determination or subsequent appeal determination. This may or may not result in the release of additional benefits.
Post-Service	Any claim for benefits that are not pre-service. Post service issues are not eligible for an expedited process. This includes: • Pharmacy appeals where the service doesn't require preauthorization or prior approval are considered post service appeals. Preauthorization for pharmacy includes step therapy and prior authorization requirements. There are specific lists for the drugs included in these requirements. • Post service appeals also include rescissions of coverage for all plan types and declinations of coverage for individual plans only. For Pre-Service requests, when the service is rendered during the course of the appeal process, the appeal is still completed within the timeframe for resolution of a pre-service appeal.

	For pre-Service requests that have services rendered prior to subsequent appeal requests, the next level of review is handled as a new post service level 1 appeal. If there is an adverse determination and the service has been rendered but we have not received a claim, this is considered a post service appeal. The claim denial is not necessary for an appeal to be a post service appeal.
Potential Quality of Care Concern	A concern raised by anyone internal or external to the health or dental plan that requires investigation as to whether the competence[3] or professional conduct of an individual Aetna network practitioner, organizational provider, or vendor adversely affects, or could adversely affect, the health or welfare of a member.
Pre-Certification	The prospective process of collecting information prior to inpatient admissions and performance of selected ambulatory (i.e., outpatient) procedures and services that appear on Aetna's pre-certification list, plan sponsor specific precertification list or SPD and the making of an initial determination of benefits for those care or services. Services on the precert list that require notification only are not denied on initial precertification and therefore, generally do not qualify as preservice denials.
Pre-Determination	A benefit request made prior to the services being rendered for coverage of care or services that are not listed on the national pre-certification list. **Note**: Pre-determinations are not considered claims for benefits under the DOL regulations. If the service is rendered during the timeframe of the receipt of the pre-determination request, the request for care or services is no longer considered a pre-determination. **Predeterminations are not eligible for appeal**. However, once the service is rendered; the decision can be appealed but it is no longer considered a pre-determination. It follows the post service claim denial path.
Pre-Service	A benefit request of coverage for care or services where: • The terms of the plan state that Aetna must approve in whole or part the benefit in advance of the member obtaining the service (i.e., services require pre-certification), and • The services have not been rendered Appeals of pre-service are categorized and managed through the Aetna pre-service appeal process. If the service is rendered during the course of the appeal process, the appeal is still completed within the timeframe for resolution of a pre-service appeal. If the service is rendered prior to subsequent appeal requests, the next level of review is handled as a new post service level 1 appeal. If there is an adverse determination and the service has been rendered but we have not received a claim, this is considered a post service appeal. The claim denial is not necessary for an appeal to be a post

[3] For purposes of this policy, the term "competence" includes an assessment of clinical management skills.

	service appeal.
Prospective	Care or services not yet rendered. Prospective services are categorized as either a Pre-Determination or Pre-Service (Pre-certification).
Protected Health Information (PHI)	Information created or reviewed by Aetna that relates to the past, present or future physical or mental condition of a member; or to the provision of or payment for his/her health care. PHI is information that either identifies, or there is reason to believe that it could be used to identity a member
Quality of Service Complaint	A concern raised by anyone internal or external to the health or dental plan indicating that the service the member received was not to the member's satisfaction. Examples include, but are not limited to rude office staff, unsanitary office, long travel distances or an issue with services provided by Aetna (e.g. Customer Service and Aetna Specialty Pharmacy).
Regulatory Complaint	A complaint that originates from any state or federal agency concerning Aetna's products and services.
Relevant Documents	A document, record, or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information (i) Was relied upon in making the benefit determination; or (ii) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; or (iii) Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination; or (iv) In the case of a group health plan or a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.
Reporting - Complaint and Appeal Tracking System (CATS)	Reporting plays a critical role in Aetna's delivery of best-in-class service for handling and responding to member and provider complaints, grievances, and appeals. The Reporting Team delivers reports which support the data needs of both internal and external constituents, including regulatory entities, plan sponsors, and CG&A operational units. Reports can be generated using most of the data input into CATS, including but not limited to state, appeal category, plan type, who is the request on behalf of, provider of service, etc. Certain data is captured systemically and certain data is entered manually. Data that is entered is manually into the system, the system will capture what is manually entered and not interface with other systems. .
Rescission of Coverage	A rescission of medical coverage means that the member's coverage has been terminated back to their original effective date, as if they never had coverage with Aetna. A rescission is done only after a lengthy internal investigation which involves medical record review, communication with the member, establishment of treatment and medical history timelines, etc., the outcome of which demonstrates that the member knowingly committed fraud or intentionally misrepresented his/her health status which materially affected our evaluation of the risk.
Retrospective Review	Retrospective review is the process of reviewing coverage[4] requests for initial certification:

[4] For these purposes, "coverage" means either the determination of (i) whether or not the particular service or treatment is a covered benefit pursuant to the terms of the particular member's benefit plan, or (ii) where a provider is

	• After the service has been provided or; • When the member is no longer inpatient or receiving the service. o A review initiated while a member is hospitalized is considered a concurrent review. o A review as the result of a precertification adverse coverage determination or claim denial is considered an appeal. The process of reviewing coverage requests for care or services requiring precertification after the care or service has been provided (i.e., when the member is no longer inpatient or receiving the care / services). Retrospective review includes making coverage determinations for the appropriate level of service consistent with the member's needs at the time of service prior to the claim payment process.
Same / Similar Specialty	A review performed by a board certified physician with a current, active, unrestricted license to practice medicine or a health professional in the same or similar specialty who typically treats the medical condition, performs the procedure or provides the treatment under review. The *same specialty* refers to a practitioner with similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal. A *similar specialty* refers to a practitioner who has experience treating the same problems as those in question in the appeal, in addition to experience treating similar complications of those problems.
Uphold	To maintain the initial determination or subsequent appeal determination.
Urgent Care	A case involving medical or dental care or treatment where a delay in decision-making might seriously jeopardize the life or health of the member or jeopardize the member's ability to regain maximum function; or in the opinion of a healthcare professional with knowledge of the member's medical or dental condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal
Utilization Review	A formal evaluation (preservice, concurrent or postservice) of the medical necessity, efficiency or appropriateness of health care services and treatment plans.

Section III – Complaint Standards

A. Resolution Timeframes

Category	Timeframe
Expedited Complaints[5]	5 calendar days
Standard Complaints	30 calendar days
Executive Complaints	30 calendar days or as outlined in the Executive, Legislative and Better Business Bureau Complaint Procedure

required to comply with Aetna's patient management programs, whether or not the particular service or treatment is payable under the terms of the provider agreement.

[5] Expedited complaints will be resolved sooner than stated if required due to a member's medical or dental condition.

Regulatory Complaints	• Within the state or federal specific timeframe or the timeframe indicated by the requestor. • For follow up requests, resolve within the timeframe the regulator indicates or 10 calendar days. For urgent follow up issues, contact the requestor for TAT.

B. Case Processing

Complaints must be handled in accordance with the standards outlined in the Policy and Procedure related to:

1. Acknowledgement letters, if requested or required by state or federal law or regulation
2. Full and fair review (as described in "C" below)
3. Resolution time frames (as described in "A" above)
4. Resolution letter requirements (as described in "D" below)
5. Record of the complaint and its resolution
6. Offering of translation of complaint correspondence in the appropriate language following federal guidelines.

C. Full and Fair Review

Complaints must be handled in accordance with the Full and Fair Review standards outlined in the Policy and Procedure:

1. Accept complaints from a member or their authorized representative regardless of the length of time until the complaint submission.
2. Evaluate and coordinate investigations with the appropriate Aetna personnel, Subject Matter Experts (SME), as necessary including any aspects related to clinical care.
3. Allow extensions, as appropriate, when there is a delay in receiving requested information which is necessary for the resolution of the issue.

D. Resolution Letter Requirements

Resolution letters will be sent to the complainant or their authorized representative.
The required letter components are as follows:

1. A statement of the reviewer's understanding of the complaint
2. Notification to the member of the disposition of the complaint
3. The right of appeal, where required by law or regulation or as applicable.
4. Content should be limited to the minimum necessary to provide a complete response while protecting the privacy of the individuals involved and meeting regulatory requirements.

Section IV – Appeal Standards

A. General

Levels of Appeal
Standard
Aetna's standard is to offer a two-level appeal process for all Aetna plans except individual medical plans. Individual medical plans only receive one level of appeal for all types of appeals based on federal law. .

The below appeal process is superseded by any appeal process required by law or regulation, or as described in the governing Certificate of Coverage or Summary Plan Description.

Corporate Appeals Committee[6]

It is the responsibility of the Corporate Appeals Committee (CAC) to handle all second and/or final level appeals for medical necessity regarding any of the National Medical Excellence (NME) programs and to handle other second level appeals identified as appropriate by the Regional Medical Directors. The CAC will also handle final level appeals of benefit denials and benefit level reductions for NME issues when there is a clinical component to review. Refer to the Corporate Appeals Committee Policy and Procedure

B. Timeframes

The appeal resolution timeframes are shown below and are calculated from the date / time the appeal is received by Aetna or their designee.

Note: The timeframes noted below are not applicable for Federal Employees Health Benefit Plan [FEHBP]. Refer to the FEHB Workflow on the CG&A website for the FEHBP timeframes.

Standard Process (two levels)

Category	Level One	Level Two
Expedited Appeals[7]	36 hours	36 hours
Pre-Service Appeals	15 calendar days	15 calendar days
Post-Service Appeals	30 calendar days	30 calendar days

Individual and One Level Process

Category	Level One
Expedited Appeals[7]	72 hours
Pre-Service Appeals	30 calendar days
Post-Service Appeals	60 calendar days[8]

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C. Case Processing

Appeals must be handled in accordance with the following standards:

1. Timeframes to submit appeals
2. Acknowledgement notification as required by state or federal law or regulation or plan document
3. Full and fair review (as described in "D" below)
4. Case investigation / decision timeframes
5. Resolution letter timeframes
6. Resolution letter contents (as described in "E" below)
7. Record of the appeal and its resolution
8. Offering of translation of appeal correspondence in the appropriate language following Federal regulation.

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[6] Does not apply to Dental Products

[7] Expedited appeals will be resolved sooner than stated if required due to a member's medical condition.

D. Full and Fair Review

Appeals must be handled in accordance with the Full and Fair Review standards outlined in the Policy and Procedure:

1. Allow a member or a member's authorized representative 180 calendar days to submit a level one appeal after receipt of the notification of an initial adverse determination.
2. Allow a member or a member's authorized representative 60 calendar days to submit a level two appeal after receipt of the level one appeal resolution letter, when applicable.
3. Allow any active member to submit an appeal on behalf of their covered spouse or dependent child.
    a. If the requestor does not meet the definition of an authorized representative process the appeal; however, provide a response only to the member who is the subject of the appeal.
4. Provide members or their authorized representatives the opportunity to submit written comments, documents records, and any other information relevant to the member's appeal.
5. Take into account the substance of the appeal and all comments, documents, records and other information submitted by the appealing party without regard to whether such information was submitted or considered in the initial benefit determination.
6. Ensure that all documentation necessary to complete a review has been requested and taken into account including anything received after the appeal request but prior to resolution of the appeal.
7. Complete reviews that do not afford deference to the initial adverse benefit determination or subsequent adverse determinations and that are conducted by individuals not involved in the initial determination process or subsequent adverse determinations – handling – prep, etc, or a subordinate of that person who rendered the initial determination or subsequent adverse determination.
8. Coordinate appropriate expertise of the appeal decision maker(s):
    a. Coordinate case investigations with the appropriate Aetna Subject Matter Experts (SME) as necessary to assure issues are properly evaluated, including any aspects related to clinical care.
    b. Consult with health care professionals (board certified as necessary) who have appropriate training and experience in the field of medicine (Same/Similar Specialty) for review of appeals of any adverse determination that is based in whole or in part on medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate. This consultation is performed during the final level of appeal (if there is only one level of appeal available, it would be done at that level, otherwise it is done at the second level of appeal), with the exception of Behavioral Health (which will continue to be performed during the first level of appeal).
    c. Convene committee/panel reviews, as required by regulation or plan documents.
    d. Allow extensions upon member request if they are unable to meet the panel review timeframe.
9. Expedite appeal investigations and resolution notices for urgent care, including urgent concurrent care and/or services.
10. Allow extensions, as allowed by federal regulations, when the appellant voluntarily agrees to the extension.
11. Continue coverage of previously approved services pending the outcome of the appeal.
12. On the final level of appeal, allow the appellant the opportunity to review any new information reviewed prior to making the final adverse determination.
13. Provide members or their authorized representatives, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the member's claim for benefits.

14. Appeal reviewers do not receive incentives for their reviews / decisions and do not discriminate against anyone when making determinations.
15. Notify the appellant of all appeal information in a culturally and linguistically appropriate manner as required by regulations to ensure meaningful access to notifications.
16. Allow appellant to request an explanation in writing why Aetna determined that it met the criteria of strict adherence to the Affordable Care Act. Aetna will respond to that request within 10 days.

Committee Review

Aetna provides committee reviews for appeals when required by a state or federal law or regulation or when a committee review process is included in the governing certificate of coverage/summary plan description.

Committee Composition

The committee composition will be based on the state or federal mandate or requirement or as outlined in the governing certificate of coverage/summary plan description. In the absence of such requirements, it will be comprised of a minimum of three plan representatives. If the determination, in whole or part, involves medical judgment, there will be at least one plan Medical Director.

Member Rights for Committee Review

During a committee review, a member is entitled to:

- Participate in the review
- Present their case in writing or directly to the committee
- Submit supporting material both before and during the review meeting
- Choose someone to assist them, this person may be an attorney

E. Resolution Letter Requirements

Resolution letters will be sent to the appealing party and the provider and the facility (when applicable). The required letter components are as follows:

1) Approvals (overturns)
   a) A statement of the reviewer's understanding of the pertinent facts of the appeal (description of the health/dental care service/claim).
   b) An explanation of the decision, including any instructions and/or payment information in easy-to-understand language that a layperson would understand and which does not include abbreviations or acronyms that are not defined or health care procedure codes that are not explained.

2) Denials (full and partial)
   a) A statement of the reviewer's understanding of the pertinent facts raised / submitted by the appellant (description of the health or dental care service / claim).
   b) Date of service, provider of service, amount of the claim and denial codes and their descriptions, when applicable to the case. Disclaimer that the ICD9/ICD10 or procedure code information is available upon request.
   c) Evidence or documentation used for the basis of the decision.
   d) The decision in clear terms in easy-to-understand language, including a complete explanation of the grounds for the denial written in plain language that a layperson would understand and which does not include abbreviations or acronyms that are not defined or health care procedure codes that are not explained.
   e) A statement explaining the status of claims that are not eligible for reimbursement and have already been processed.
   f) An explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the member's medical or dental circumstances in easy-to-understand language including a complete explanation of the grounds for the denial written in plain

language that a layperson would understand and which does not include abbreviations or acronyms that are not defined or health care procedure codes that are not explained..

g) The specific rule, guideline, protocol or other similar criterion that was relied upon in making an adverse determination
h) A statement that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the member upon request.
i) The specific plan provisions on which an adverse benefit determination is based.
j) The body of the letter must include the information noted below. Note: *the signature line of the letter does not meet the intent of the requirement for titles and qualifications.*
k) For a benefit appeal, the title of each reviewer, OR
    i) For medical necessity appeals, the title and qualifications of individuals who participated in the decision making process – including the specialty of each clinical reviewer
    ii) Specifically state that the individual(s) participated in the appeal review and that specific names are available upon request.
l) A statement that the member is entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records, and other information relevant to the member's appeal.
m) A description of further appeal rights, if applicable, including time frames and how to file.
n) The following statement: "If you do not agree with the final determination on review, you have the right to bring a civil action under Section 502(a) of ERISA."
Note: This does not apply to plans that are not required to follow ERISA guidelines.
o) The availability of external review and how to request it, if applicable
    i) include the right to obtain additional information related to external review.
    ii) include a statement that the member is not responsible to bear cost of the external review.
p) Offer of assistance by the applicable State Ombudsman program following Federal regulation
q) Content should be limited to the minimum necessary to provide a complete response while protecting the privacy of the individuals involved and meeting regulatory requirements.
r) The following statement:
    i) Fully insured
        (a) "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency."
    ii) ASC (self insured)
        (a) "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your Plan Administrator or your local U.S. Department of Labor Office."

Related Materials

Policies	• Corporate Appeals Committee Policy • External Review Policy • Privacy Complaints and Sanctions Policy • Provider Complaint and Appeal Policy • Records Retention and Management Policy • Review of Potential Quality of Care Concerns Policy • State-Specific External Review Policies • State-Specific Member Complaint and Appeal Policy Addenda

Procedures	• Corporate Appeals Committee Procedure • Dental Member Complaint Procedure • Dental Member Appeal Procedure • Member Appeal Procedure When the Plan Sponsor is the Claim Fiduciary • Member Complaint Procedure • Member Complaint and Appeal - Authorized Representative Procedure • Regulatory Complaint Procedure
Related Tools	• Addressing Appeal Resolution Letters Guidelines • Voiance Language Line • Certificates of Coverage (COC) Summary Plan Descriptions (SPD) or Summary of Coverage (SOC) • State Specific Member Appeal Processing Guide • Claim Fiduciary Chart • Documentation Guidelines • Federal Employees Health Benefit Program (FEHB) Workflow • Instructions for Identifying Plan Sponsor Claim Fiduciary Process • Lack of Information Workflow • Language Translation Workflow • Member Electronic Imaging Workflow • Plan Sponsor Tool • Receiving Calls from Members with Limited English Proficiency • Resolution Team Routing Guide • Request for Relevant Documents Workflow • Roles and Responsibilities Summary • Panel Hearing Workflow • Member Letter Selection Guides • NCM 505-01 Denial of Coverage

Approval to Implement:

Review Council/Policy Committee Signature Designee:

Signature on file	Date
Shannon Thomas	10/09/2018